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HOWARD LEE MITCHELL III, M.D.

Case No. MD-06-0256

INTRODUCTION

The above-captioned matter came on for discussion before the Arizona Medical Board ("Board") on April 21, 2006. After reviewing relevant information and deliberating, the Board considered proceedings for a summary action against the license of Howard Lee Mitchell, M.D. ("Respondent"). Having considered the information in the matter and being fully advised, the Board enters the following Interim Findings of Fact, Conclusions of Law and Order for Summary Suspension of License, pending formal hearing or other Board action. A.R.S. § 32-1451(D).

INTERIM FINDINGS OF FACT

2. Respondent is the holder of License No. 30004 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-06-0256 after receiving a complaint regarding Respondent's care and treatment of a twenty-three year-old female patient ("JL"). The complaint alleged Respondent continually over-prescribed inappropriate controlled substances without a proper diagnosis or consultations even after JL's successful inpatient detoxification for opioid addiction.

4. Included in Respondent's records were records from JL's gynecologist and anesthesiologist from Texas for the period of November 2002 to August 2003. The gynecologist

1 diagnosed JL with endometriosis, adenomyosis, dysmenorrhea, and depression. The
2 medications prescribed by the gynecologist appear to be limited to Lupron and an occasional
3 prescription for Darvocet and NSAID. The gynecologist also discussed with JL acupuncture,
4 chiropractics and vitamins as possible pain management methods. The records indicate JL was
5 referred by her gynecologist to the anesthesiologist for pain management consultation on
6 September 12, 2003 and that JL remained in the anesthesiologist's care for two months. The
7 anesthesiologist noted a two-year history of chronic pelvic pain in the then twenty-year-old JL.
8 JL gave the anesthesiologist a history of having been raped at seventeen years-old and
9 identified current symptoms of weight loss, joint pain, depression, anxiety and insomnia in
10 addition to her chief complaint of pelvic pain. The anesthesiologist's impression was "multi-
11 factorial pelvic pain syndrome including endometriosis, complex regional pain syndrome of the
12 pelvic type" and a history of emotional and sexual trauma.

13 5. The anesthesiologist treated JL with a spinal cord stimulator, but it provided no
14 benefit and caused an increase in her pain complaints. The anesthesiologist also performed a
15 superior hypogastric nerve block, but after transient benefit, JL's pain returned and was more
16 severe than prior to the block. Medication management included Neurontin, but it provided no
17 benefit to JL. Xanax helped JL with her reported obsessive compulsive disorder. The
18 anesthesiologist replaced JL's Norco with Talwin and JL requested an early refill of Norco on
19 November 3, 2003. There are no records of subsequent care provided by the anesthesiologist
20 after November 2003.

21 6. Respondent initially evaluated JL on December 23, 2003. He noted problems
22 with insomnia, ruminations, helplessness, hopelessness, panic attacks and paranoia; JL had
23 been raped twice during drinking blackouts at age seventeen and eighteen; problems with pelvic
24 pain, low back pain, endometriosis and adenomyosis; JL's current medications were Percocet bid,
25

1 Duragesic 25 microgram patch q three days, and Xanax 0.5 mg tid. Respondent did not note a
2 psychiatric diagnosis or discernible plan in the initial consultation note.

3 7. Copies of prescriptions written by Respondent reveal barely legible prescriptions.
4 Respondent's file contained cursory hand-written office notes from January 8, 2004 through
5 March 17, 2006. During this time period Respondent introduced and adjusted various opioid and
6 non-opioid medications for chronic pain and anxiety. JL's chart contained no ordered, sequential
7 listing of medications prescribed either in office notes or in the form of a flow sheet.
8 Respondent's prescribing pattern was deciphered using copies of written prescriptions contained
9 in Respondent's medical records. Examination of these prescriptions identifies a pattern of
10 repeated early refills and escalating dosages of controlled substances.

11 8. Respondent appropriately obtained a consultation for JL with a spine surgeon who
12 noted JL's problems were "very minimally spine related." Respondent also appropriately referred
13 JL to a gynecologist. The gynecologist authored a letter to Respondent expressing her opinion
14 that the opioid dosage seemed excessive for the medical conditions and represented a "legal
15 narcotic addiction." Respondent's records do not reflect consideration of opinions of either the
16 spine surgeon or the gynecologist. There appears to be no consideration of the disparity
17 between subjective complaints and the experts' opinions.

18 9. From the time of Respondent's initial evaluation the escalation and early refills of
19 controlled substances culminate in the October 14, 2005 prescriptions for Soma, MSContin tid, a
20 prescription for Oxycontin 80 mg four tid plus two bid prn breakthrough pain (the notation on the
21 prescription is "s/p surgeries and chronic pain"). Respondent did not document what type or
22 when surgeries had been performed, or whether the surgeon was involved in the post-operative
23 pain management. Respondent did not document a rationale for simultaneous use of two
24 different sustained release opioids or for the use of a sustained release opioid for breakthrough
25

1 pain. If the medication was taken as directed it could result in JL taking a sustained release
2 opioid eight times per day.

3 10. According to the complaint received by the Board it was during this time frame of
4 late-fall 2005 that JL required emergency care on two occasions for seizures. JL then underwent
5 successful inpatient detoxification for opioid addiction from November 16 through 23, 2005. Two
6 weeks later Respondent wrote prescriptions for escalating dosages of Oxycontin on five
7 occasions between December 6, 2005 and January 17, 2006. This prescribing includes identical
8 prescriptions for #240 Oxycontin 80 mg on two consecutive days – January 16 and January 17,
9 2006.

10 11. On January 27, 2006 Respondent wrote additional Oxycontin prescriptions,
11 despite the fact that if JL had consumed the January 16, 2006 and January 17, 2006
12 prescriptions for #480 Oxycontin 80 mg she would have taken six times the amount prescribed
13 by him, thus exhausting a sixty day supply of Oxycontin in ten days. This would equal nearly
14 four grams of Oxycontin per day, a dosage that is unlikely to be compatible with JL, a 150 pound
15 individual, remaining conscious long enough to consume it all, regardless of her tolerance.
16 Without apparent consideration of the severe noncompliance with his prescription instructions
17 and/or the possibility of diversion and without seeing JL, Respondent wrote new prescriptions for
18 a thirty day supply of 1200 mg Oxycontin per day and 360 mg Avinza ghs on January 27, 2006.

19 12. Beginning two weeks later Respondent wrote four different thirty-day prescriptions
20 for sustained release opioids at four to seven day intervals, over a seventeen day period in
21 February 2006 without any office visit. In March 2006, within a twenty-four hour time-frame and
22 in the absence of an office visit, Respondent wrote five prescriptions for three different sustained
23 release opioids, three prescriptions for two benzodiazepines, and one prescription for Percocet.
24 Respondent added the benzodiazepines without any apparent precautionary measures to
25 mitigate the potentiation of central nervous system depression. Five days later, JL was treated in

1 the emergency department for acute psychosis and was subsequently transferred by ambulance
2 to an inpatient detoxification center for detoxification for opioid addiction. Respondent has
3 written no additional prescriptions, presumably since JL has been living in a halfway house
4 undergoing treatment for opioid addiction.

5 13. Physicians are required to maintain adequate legible medical records containing
6 at a minimum, sufficient information to identify the patient, support the diagnosis, justify the
7 treatment, accurately document the results, indicate advice and cautionary warnings provided to
8 the patient and provide sufficient information for another practitioner to assume continuity of the
9 patient's care at any point in the course of treatment. Based on the above, Respondent's
10 medical records for JL are inadequate.

11 14. The standard of care for treating a patient with chronic nonmalignant pain requires
12 consideration of expert consultants' opinions, patient monitoring, warranted dose escalations,
13 presence of sound pharmacologic principles, and rational polypharmacy.

14 15. Respondent deviated from the standard of care because he did not consider the
15 opinions of experts to whom he referred JL, did not monitor JL, prescribed unwarranted dose
16 escalations, did not demonstrate sound pharmacologic principles, and displayed irrational
17 polypharmacy.

18 16. JL was harmed because she became addicted to opioids, underwent two inpatient
19 opioid detoxifications, underwent emergent treatment for opioid related problems, and serious
20 psychosocial issues were ignored and exacerbated.

21 17. JL was potentially harmed because she could have overdosed and died after
22 taking the narcotics prescribed by Respondent.

23 18. The facts as presented demonstrate that the public health, safety or welfare
24 imperatively requires emergency action.
25

1 **INTERIM CONCLUSIONS OF LAW**

2 1. The Board possesses jurisdiction over the subject matter hereof and over
3 Respondent, holder of License No. 30004 for the practice of allopathic medicine in the State of
4 Arizona.

5 2. The conduct and circumstances described above constitute unprofessional
6 conduct pursuant to A.R.S. § 32-1401(27)(e) ("[f]ailing or refusing to maintain adequate records
7 on a patient"); 32-1401(27)(j) ("[p]rescribing, dispensing or administering any controlled
8 substance or prescription-only drug for other than accepted therapeutic purposes"); 32-
9 1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health or
10 the patient or the public"); and 32-1401(27)(ll) ("[c]onduct that the board determines is gross
11 negligence, repeated negligence or negligence resulting in harm to or the death of a patient").

12 3. Based on the foregoing Interim Findings of Fact and Conclusions of Law, the public
13 health, safety or welfare imperatively requires emergency action. A.R.S. § 32-1451(D).

14 **ORDER**

15 Based on the foregoing Interim Findings of Fact and Conclusions of Law, set forth above,
16 IT IS HEREBY ORDERED THAT:

17 1. Respondent's license to practice allopathic medicine in the State of Arizona,
18 License No. 30004, is summarily suspended pending a formal hearing before an Administrative
19 Law Judge from the Office of Administrative Hearings.

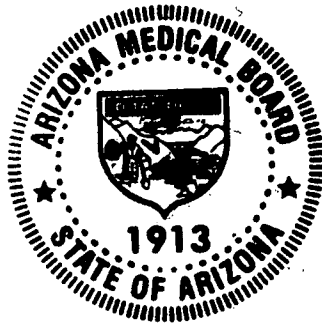
20 2. The Interim Findings of Fact and Conclusions of Law constitute written notice to
21 Respondent of the charges of unprofessional conduct made by the Board against him.
22 Respondent is entitled to a formal hearing to defend these charges as expeditiously as possible
23 after the issuance of this order.

24 3. The Board's Executive Director is instructed to refer this matter to the Office of
25 Administrative Hearings for scheduling of an administrative hearing to be commenced as

1 expeditiously as possible from the date of the issuance of this order, unless stipulated and agreed
2 otherwise by Respondent.

3 DATED this 21st day of April 2006.

4
5 [SEAL]



ARIZONA MEDICAL BOARD

6
7
8 By Amade Rich
9 Timothy C. Miller, J.D.
Executive Director

10 ORIGINAL of the foregoing filed this
11 21st day of April, 2006, with:

12 Arizona Medical Board
13 9545 East Doubletree Ranch Road
14 Scottsdale, Arizona 85258

15 EXECUTED COPY of the mailed by
16 ~~US certified mail~~ this 21st day of
17 April 2006 to:

18 Howard Lee Mithell III, M.D.
19 (Address of record)

20 Executed copy of the foregoing mailed by
21 first class mail this 21st day of April 2006
22 to:

23 Dean Brekke
24 Assistant Attorney General
25 Arizona Attorney General's Office
1275 West Washington, CIV/LES
Phoenix, Arizona 85007

26 Jim McGraw